

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031022

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 252 Primary Registration District No. 6189 Registrar's No. 69

FILED JUL 29 1963

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Taney | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Taney | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Forsyth | | c. CITY OR TOWN Forsyth | |
| Length of stay in 1b 3 Yrs | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeview Rest Home | | d. STREET ADDRESS (If outside, give location) Lakeview Rest Home | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|---------------------------|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Harry Wilson Bell | | | 4. DATE OF DEATH Month Day Year July 25 1963 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-25-1872 | 9. AGE (last birthday) 90 | IF UNDER 1 YEAR Months Days Hours Min. 9 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | 11. BIRTHPLACE (City and state or country) Lockhaven, Penn. | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME George Wilson Bell | | 13b. MOTHER'S MAIDEN NAME Sarah Cowser | | 14. NAME OF HUSBAND OR WIFE none | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. [redacted] | | 17. INFORMANT Mrs M.H. Forgey Kansas City, Kansas | |

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO (b) <u>Cerebral Hypertension</u> DUE TO (c) <u>Senility</u> | | INTERVAL BETWEEN ONSET AND DEATH .. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from 4-9-60 to 7-25-63 and last saw him alive on 7-25-63 Death occurred at 1:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|---|------------------------|---|---|-----------------------------|
| 22a. SIGNATURE Mary King, D.O. | | 22b. ADDRESS Forsyth, Mo. | | 22c. DATE SIGNED 7-26-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7-25-1963 | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery | 23d. LOCATION (City, town, or county) St. Joseph, Missouri | (State) |
| 24. FUNERAL DIRECTOR Meierhoffer F. Home St Joseph, Mo | | 25. DATE RECD. BY LOCAL REG. 7-27-63 | 26. REGISTRAR'S SIGNATURE Aileen Campbell | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
1 1060
2 1060
3
4 0
5 0
6
7 1
8 2
9 332X
10
11
12 86-2
13 1-0

AUG 1 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4731

P. O. Address Shannon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.